The impact of masculinity upon men with psychosis who reside in secure forensic settings

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STRUCTURED ABSTRACT

Purpose

Masculinity is a core cognitive structure that plays a central role in organising attitudinal and behavioural processes. Yet there is limited research focusing upon the meaning of masculinity for men who have a past history of violent behaviour, experience psychotic phenomena and reside in secure forensic settings.

Design/methodology/approach

Q methodology was used to elucidate the factors regarding how men who experience psychotic phenomena perceive their masculinity. Ten participants from a secure forensic setting performed a 49 statement Q-sort task.

Findings

Principle component factor analysis with varimax rotation was performed on the 10 completed Q sorts which revealed a 3 factor solution, accounting for 57% of the variance in the data. The factors were interpreted and discussed under the following headings: “assured and asserting maverick”, “calm, confident, composed conformist” and “nurturing provider in the face of adversity”. This revealed that men with psychosis have different, predominantly pro-social explanatory frameworks for their representation of masculinity.

Research limitations/implications

This study revealed that men with psychosis have different, predominantly pro-social explanatory frameworks for their representation of masculinity. However, the study was limited by its lack of longitudinal assessment and the inclusion of a greater number of participants may have enhanced the representativeness and generalizability of the findings.

Practical implications

Therapeutic discussions in respect of masculinity itself could provide men with the opportunity to develop newer, more adaptive conceptualisations of themselves, help them develop greater self-awareness and understanding of the sources of their presenting concerns, which in turn could enhance a provisional formulation of their

difficulties. It would also be potentially valuable to understand how these patterns of masculinity map onto coping, recovery style and service engagement. Furthermore, services could also benefit from becoming more aware of hospitalization being a shameful perhaps stigmatizing time for men with psychosis.

Social implications

It may be useful for people working in healthcare settings to be aware of how the service users they support perceive their masculinity, so the existential and deeper needs of male patients are provided with enough consideration. This is an important point, as some individuals are often reluctant or neglect to enquire about individual's psychotic experiences and gender identification.

Originality/value

Although forensic psychiatric care is primarily populated by men who have committed violent acts, there is limited research focusing upon the meaning of masculinity in this context. This is in spite of evidence which shows that maladaptive perceptions of masculinity can be reinforced during time spent residing in secure settings. The cultural constructs of masculinity and their respective impact upon the diagnosis, management, and outcome of psychosis has also received little attention. Therefore, this research represents new and significant contributions to the field.

INTRODUCTION

Research suggests that behaviours indicative of masculinity (qualities traditionally associated with men) include engaging in risky activities (Pittman, 1990; Dolan, 2011; Creighton & Oliffe, 2010), anti-effeminacy (Haldeman, 2006; Schwartzberg & Rosenberg, 1998), being sexually active and successful with women (Phillips, 2006; Terry, Hogg & McKimmie, 2000; Hyde, DeLamater & Byers, 2006), being powerful, competitive and dominant (Beaglaoich, Sarma & Morrison, 2013); not showing vulnerability, emotions, or weakness (Jansz, 2000); being successful in their work and in control of themselves, others, and their environments; (Robinson *&* Watt, 2001; Möller-Leimkühler, 2003) and sexually skilled (Barker & Ricardo, 2005).

Men who are violent tend to have a higher conformity to masculine norms (Amato, 2012) and their perception of masculinity has a role in organising their attitudinal and behavioural process (Tennant & Hughes, 1998). Although forensic psychiatric care is primarily populated by men who have committed violent acts, there is limited research focusing upon the meaning of masculinity in this context (Kumpula & Ekstrand, 2009). This is in spite of evidence which shows that maladaptive perceptions of masculinity can be reinforced during time spent residing in secure settings. For example, the environment in psychiatric units is characterised by locked doors, protection, rules, and routines (Höglund, 1996), and due to their focus upon safety and protection, characteristics such as aggressiveness and toughness can become dominant (Kumpula & Ekstrand, 2009). Furthermore, men are often reluctant to engage with psychological therapies whilst residing in secure settings due to conformity to masculine roles, namely beliefs that help-seeking is a sign of weakness which would lead them to feel inadequate and shameful (Courtenay, 2011), and lead them to be at risk of harm if they were to seen to be vulnerable by other patients (Safran, 1990). Additionally, in cases where masculinity emerges as a dominant dynamic risk factor (e.g. when the offender asserts that any man would have committed the offence in his situation), research suggests that existing interventions do not seem best equipped to respond (Whitehead, 2005). Therefore, efforts to treat and rehabilitate men who have a history of violent offending may be unlikely to usefully proceed without some consideration of the individual's concept of masculinity (Tennant & Hughes, 1998).

The cultural constructs of masculinity (Lewine, 1994) and their respective impact upon the diagnosis, management, and outcome of psychosis has also received little attention (Nasser, Walders, & Jenkins, 2002; Searle, Hare, Davies, Morgan & Majumdar, in press). The identification of societal prescriptions of gender as a distinct theme of psychosis has also not yet been identified by the psychiatric

literature (Mitropoulos et al., 2015). Yet there is overlap between perceptions of masculinity and the difficulties experienced by some individuals who experience psychotic phenomena and reside in secure settings. For example, research by Hirschfeld, Smith, Trower, and Griffin (2005) highlighted the cultural notion that men should not talk about feelings or weaknesses as being a significant factor in the development of psychosis, as it leads men to become withdrawn, bottle up their feelings and exacerbates the risk of those individuals engaging in violent acts. Furthermore, research suggests that men with psychosis are often reluctant or hesitate to talk about either the psychotic phenomena they experience or their gender identity, which reduces the likelihood of mental health professionals enquiring about individual's psychotic experiences and gender identification (Semp & Read, 2014).

Aims/objectives

This study used a cross-sectional design to systematically explore how adult males with a diagnosis of psychosis who reside in forensic settings perceive their masculinity. It was hypothesised from the research literature that the men would consider risky activities, anti-effeminacy, sexual ability and conquests, power competition and dominance, restrictive emotionality, career success and the ability to exert control over others as being indicative of masculinity.

METHOD

Inclusion/exclusion criteria

A panel of local experts within the psychosis field and men who resided at a secure forensic setting with a diagnosis of psychosis were invited to take part in this research study.

The inclusion criteria for the Clinical Psychologists included that they were experts in the field of psychosis due to research or academic knowledge, reputation or experience. Consequently, participants were accepted if they were working directly with people experiencing psychosis, or had written academic publications in respect of men with psychosis.

The service users were required to be male, be at least 18 years of age, have received a diagnosis of psychosis, have committed a violent index offence or exhibited a past history of violent offending and have resided at the clinic for at least 6 months to ensure a familiarity with their surroundings. Service users were excluded if they were experiencing an acute phase of their psychotic illness or did not have capacity to consent to their involvement. The decision as to whether participants met the exclusion criteria was discerned by liaising with the psychology team to which the service user resided, and asking them for their professional opinion.

Participants

The local experts comprised of a total of 6 clinical psychologists who took part in the development of the Q-set phase of the project from a possible 8 who were invited to the study.

All ten male service users who were invited to take part in the study consented to their involvement. Six service users were interviewed to help develop the Q-set and all ten participants completed Q-sorts. Demographic information in respect of the participants who engaged in the study is represented in Table 1.

Table 1: Participants Demographic Details

Clinical Psychologists	**Mean [SD] or (%)**
Age	44 [8.63]
Sex	
Male	4 (66.7%)
Female	2 (33.3%)
Sexual Orientation	
Heterosexual	6 (100%)
Ethnicity	
White	6 (100%)
Mean Years Qualified	16.5 [9.99]
Range	21
Service Users who were interviewed	**Mean [SD] or (%)**
Age	38.17 [10.40]
Diagnosis	
Schizophrenia	1 (0.17)
Paranoid Schizophrenia	4 (0.67)
Schizoaffective Disorder	1 (0.17)
Index Offence	
Grievous Bodily Harm	2 (0.33)
Fire Setting	1 (0.17)
Indecent Assault	1 (0.17)
Manslaughter with diminished responsibility	1 (0.17)
Unlawful Wounding	1 (0.17)
Sexual Orientation	
Heterosexual	5 (0.83)
Homosexual	1 (0.17)
Ethnicity	
White	6 (100)
Service Users who completed Q-sorts	**Mean [SD] or (%)**
Age	42.1 [12.03]
Diagnosis	
Schizophrenia	2 (20%)
Paranoid Schizophrenia	5 (50%)
Hebephrenic Schizophrenia	1 (10%)
Schizoaffective Disorder	1 (10%)
Disorganised Schizophrenia	1 (10%)
Index Offence	
Grievous Bodily Harm	2 (20%)
Fire Setting	1 (10%)
Murder	1 (10%)
Indecent Assault	1 (10%)
Manslaughter with diminished responsibility	1 (10%)
Self-neglect when in prison	1 (10%)
Unlawful Wounding	3 (30%)
Sexual Orientation	
Heterosexual	8 (80%)
Homosexual	1 (10%)
Bisexual	1 (10%)

Ethnicity	
White	9 (90%)
Afro-Caribbean	1 (10%)

Methodology

Q methodology (Stephenson, 1953) was used due to its reputation for being a robust technique for revealing individual points of view, highlighting shared understanding (Wastell, Skirrow & Hare, in press), as well as enabling the diversity of subjective beliefs to be systematically and empirically investigated without recourse to predetermined structures (Absalom-Hornby, 2012). Researcher bias is also minimised, as data used in Q methodology is generated by and structured by interested participants rather than researchers (Barry & Proops, 1999).

Procedure

Stage 1 – Development of the Q-set

To develop the initial Q-set, a range of sources of information which discussed masculinity including grey literature, websites and texts from academic papers were reviewed. Six clinical psychologists and six male service users were then interviewed to ask their opinions as to how men with psychosis perceive their masculinity. Interviews took place at the psychologist's work place and all service users were interviewed at their forensic residence. All participants were provided with a participant information sheet and required to sign a consent for before taking part. If they wished to participate, they were asked to sign the consent form and a mutually convenient time was arranged for them to meet with the chief investigator. This provided participants with a cooling off period should they change their mind. Use of a semi-structured questionnaire was used to aid discussion, and demographic information was ascertained (age, sexual orientation and ethnicity) from all participants, as it was considered likely that these different demographics would likely influence a respondent's opinions of 'masculinity'. Interviews were audio recorded using a digital recording device, and all data was anonymised during the transcription process. No further interviews were undertaken after completion of the twelve interviews, as it was considered that a 'saturation point' had been reached and that the completion of additional interviews would not add any diversity to the existing set of statements.

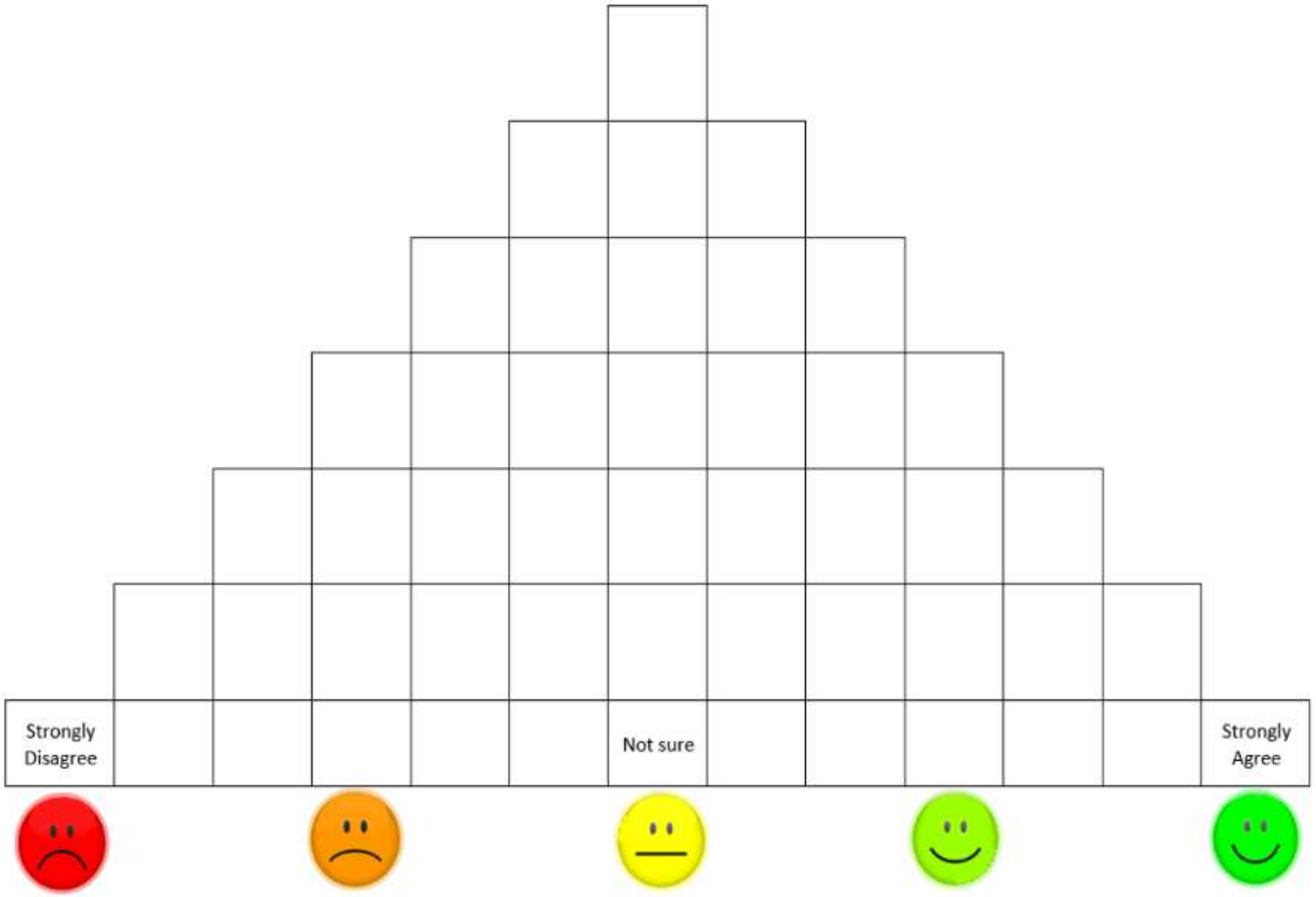
Stage 2 – Developing a Q-Sample

A Q-sample was then developed, which reduces the large set of opinion statements (182) to what was considered by the researchers to be a more manageable number (49). This led to the researchers (R.S, B.D and S.M) independently reviewing the relevance, accuracy and content of statements ascertained within the Q-set, and choosing the statements which they believed to be most representative of masculinity. This resulted in 27 statements being uniformly agreed by all three researchers and 19 being agreed upon by two researchers. The three additional statements were chosen by the chief researcher in an attempt to ensure that the brevity of masculinity was covered.

Stage 3 – The Q sort

All ten service users then completed Q-Sorts. Participants were asked to read each statement in turn and then allocate it to a quasi-normal distribution according to their agreement or disagreement with the statements (Stephenson, 1953; Brown, 1980). This included one of 13 categories (e.g. +6 = strongly agree, +3 = agree, 0 = neutral, -3 = disagree, -6 = strongly disagree) (see Figure 1). In performing this process, the participants were simultaneously ranking and rating each statement against all others in the Q-set.

Figure 1



Stage 4 – Factor Analysis

The ten completed Q sorts were then entered into PQMethod 2.11 (Schmolck & Atkinson, 2002), and the inter-correlations amongst Q sorts were then subject to factor analysis using principle component analysis. Varimax procedure was used to rotate the factors in an attempt to maximise the dispersion of factor loadings within the factors, thereby increasing the sum of variance explained by the extracted factors. The ensuing factor sort showed the similarities between individuals, and enabled the identification of exemplar Q sorts that defined each factor. These were

the statistically weighted average of all of the sorts that loaded significantly onto each factor (Z score) (Schmolck & Atkinson, 2002).

RESULTS

The ten Q sorts yielded eight factors with eigenvalues ≥1.00 (Kaiser, 1960). PQMethod 2.11 is limited to rotating eight factors maximum, which highlighted the heterogeneity of masculinity within this population. However, upon review, there was a significant overlap between factors. Consequently, each factor rotation was examined to discern how many participants loaded significantly onto each factor. From this, it was highlighted that for a four factor solution only four participants loaded significantly onto either of the factors, whereas for a three factor solution, nine participants loaded significantly onto either of the three factors. Following this, a decision was made to retain a three factor solution.

The loading onto each factor could potentially range from 1.0 (complete agreement) to 0 (no agreement) and to -1.0 (complete disagreement) (Webler et al., 2007). For the present study, a high loading was calculated using the formula 1.96 / √N, where N= number of statements. Therefore, a minimum loading of 0.28 was necessary for Q participants' data to be considered as having a high degree (95%) of statistical confidence that it contributed towards the perception (Brown, 1980).

As can be seen in Table 2, three participants loaded onto Factor 1. Three participants loaded onto Factor 2 and two participants loaded onto Factor 3. No participant loaded significantly onto more than one factor, and no factor substantially correlated with the other factors. Therefore, these factors should be considered to be distinct from each other.

Table 2: Rotated factor matrix and defining Q sorts

Participant Number	Factor 1	Factor 2	Factor 3
1	-0.0274	**0.5299***	**0.3031**
2	**0.5776**	0.2427	**0.5527**
3	**0.3058**	**0.6877***	0.1725
4	**0.8230***	-0.0185	0.1064
5	0.1452	**0.3882**	**0.6875***
6	**0.4096**	**0.4173**	**0.2804**
7	0.1561	**0.8134***	-0.0273
8	**0.4721***	0.2259	0.2780
9	**0.6744***	0.1888	0.0127
10	0.1369	0.0101	**0.8723***
Eigenvalue	3.7000	1.0389	0.9911
Cumulative % of explained variance	37%	47%	57%

Note: All significant loadings in bold, asterisk demarks exemplar loadings that define that factor.

All the Q set statements relating to the factors are listed below (average factor scores for people in the groupings are given in parentheses).

Factor 1: **Assured and Asserting Maverick**

Three participants exemplified the principal factor, accounting for 37% of the total variance. Pre-eminent in this factor is the idea that a man should not actively seek out problematic situations, but be self-assured, take action and assert themselves even when faced with risk. For example, in regards to not looking for problems, participants agreed with statement 7 (+6) "*A man does not go looking for trouble*".

In regards to being self-assured, participants strongly agreed with statement 40 (+4) "*Men should be confident*" and for taking action participants agreed with statement 14 (+5) "*Men should be competitive*", statement 9 (+3) "*Men should stop others form being hurt*" and statement 11 (+4) "*Arguing back with voices who belittle you is the right thing to do*".

In regards to risk, participants agreed with statement 46 (+3) "*It is important for a man to take risks even if he might get hurt*" and statement 48 (+3) "*A man should break the rules occasionally*". Although participants disagreed with statement 49 (-5) "*Men should rebel against society*", this may have been due to it being perceived as an extreme sense of risk taking.

A second emergent theme was that participants considered their sexual functioning as opposed to the number of their sexual conquests as being indicative of their masculinity. For example, participants agreed with statement 33 (+4) "*A man should be able to get erections*" but disagreed with statement 31 (-3) "*A man should have sex with as many women as possible*".

Participants who exemplified this factor held no objection to showing weakness or emotion. For example, participants strongly disagreed with statement 22 (-6) "*Men who cry are weak*" and statement 28 (-4) "*A man should use drugs to cope with their emotions*". However surprisingly, participants agreed with statement 25 (+5) "*Men should not be vulnerable*". Therefore, this statement may have been interpreted as being indicative of susceptibility or defenceless as opposed to emotional vulnerability. Furthermore, participants were happy to receive help from others, as participants disagreed with statement 21 (-5) "*A man should prefer to be ill than ask for help*" and statement 37 (-4) "*Men should be able to solve problems on their own*". Additionally, participants held no anti-gay attitudes, as participants disagreed with statements 45 (-4) "*I would be uncomfortable to be with a gay man on my own*", statement 43 (-2) "*A man should never compliment another man*" and statement 42 (-3) "*I would think less of another man if I were to find out he was gay*".

Factor 2: **Confident, calm, composed conformist**

Accounting for 10% of the total variance, three participants exemplified this factor, which emphasised that a man should be a confident, calm, composed conformist. Participants strongly agreed with statement 6 (+4) "*A man talks his way out of trouble*" and statement 10 (+4) "*Ignoring voices who belittle you is the right thing to do*". Perhaps unsurprisingly, these participants strongly disagreed with statement 11 (-4) "*Arguing back with voices who belittle you is the right thing to do*".

However, in contrast to factor 1, participants were more reticent to take risks, as participants disagreed with statement 46 (-2) "*It is important for a man to take risks even if he might get hurt*" and statement 49 (-5) "*Men should rebel against society*". Nonetheless, there was also overlap with factor 1, as participants again agreed with statement 33 (+6) "*A man should be able to get erections*" but disagreed with statement 31 (-4) "*A man should have sex with as many women as possible*". Furthermore, similar to factor 1, participants held no objection to showing emotion or receiving help from others, as these participants disagreed with statements 24 (-6) "*Men should not talk about their emotions"* and statement 28 (-4) *"Men should use drugs to cope with their emotions".* As per factor 1, participants held no anti-gay attitudes, as participants disagreed with statements 45 (-5) "*I would be uncomfortable to be with a gay man on my own*", statement 42 (-3) "*I would think less of another man if I were to find out he was gay*" and statement 44 (-3) "*Men should never hold hands or show affection towards another man*".

Factor 3: **Nurturing provider in the face of adversity**

Two participants loaded onto factor 3, which accounted for 10% of the variance. This factor emphasised masculinity as being indicative of protecting and providing for family members. For example, participants agreed with statement 12 (+6) "*Men should protect and provide for their families*" and statement 41 (+4) "*Men should look after their family*". However, within this factor is the opinion that men may need to endure hardship and risk in order to be a man, as participants agreed with statements 47 (+5) "*Pain is temporary glory is forever*", and statement 46 (+3) "*It is important for a man to take risks even if he might get hurt*".

As per factors 1 and 2, participants held no objection to showing emotion or receiving help from others, as these participants disagreed with statement 22 (-6) "*Men who cry are weak*", statement 28 (-3) "*Men should use drugs to cope with their emotions*", statement 25 (-5) "*Men should not be vulnerable*", statement 23 (-4) "*Men should cope with difficulties on their own*" and statement 36 (-3) "*A man should not be reliant upon other people*". However surprisingly, participants agreed with statement 39 (+4) "*A man makes his own decisions*" which may have been participant's perceiving this statement to be inactive of autonomy as opposed to gaining/seeking help from others.

Once again, participants held no anti-gay attitudes, as participants disagreed with statements 45 (-3) "*I would be uncomfortable to be with a gay man on my own*", statement 42 (-1) "*I would think less of another man if I were to find out he was gay*" and statement 44 (-1) "*Men should never hold hands or show affection towards another man*".

DISCUSSION

The present study employed Q methodology to examine the beliefs men with a diagnosis of psychosis who reside in forensic settings hold about their masculinity. This process delineated three distinct clusters of views which highlight the heterogeneity of masculinity beliefs for this population. These included the opinions

that men should be either an "*assured and asserting maverick*", a "*calm, confident, composed conformist*" or a "*nurturing provider in the face of adversity*".

These findings are generally in contrast with previous research which suggest that men who are violent strive for power and dominance over others (Robinson & Watt, 2001; Möller-Leimkühler, 2003), and participants neither agreed or disagreed in respect of masculine statements associated with aggression and violence, appearance or types of leisure activities men should engage in. This is surprising, as threats and violence in forensic psychiatric care are common among male patients (Kumpula & Ekstrand, 2009), and all the participants had past histories and index offences in relation to acts of violence towards others. This suggests that these men may engage in violent behaviour not due an adherence to masculinity norms (e.g. "*I did it because that's what men do*"). Consequently, explanations for their past violent behaviour include feeling overwhelmed, as well as a lack of skills and abilities to manage their difficulties in a more pro-social manner.

The findings also suggest that men with psychosis believe that men should seek help and talk about their emotions, which contrasts with previous research which highlight that men who adhere to masculinity norms refrain from showing their emotions (Jansz, 2000; Hirschfeld, Smith, Trower & Griffin, 2005). There are a number of possibilities for this, including that these men did not previously have support networks to which they could confide in, that previous attempts to talk about their emotions with others were unsuccessful and/or led them to become ostracised, or because they may have now become accustomed to the provision of psychological support offered to them within their current setting.

Furthermore, despite being a factor representative of hypermasculinity (Haldeman, 2006; Schwartzberg & Rosenberg, 1998) and even though the majority of participants were heterosexual, no anti-effeminacy attitudes were highlighted across all three factors. This suggests that men with psychosis do not consider sexual orientation to be indicative of masculinity, which could act as a possible protective factor for their recovery. This includes the possibility of developing friendships and support networks with men who are a different sexual orientation to themselves. However, it is also possible that the participants lack of anti-effeminacy attitudes led the participants to become ostracised from peer groups who adhered to hypermasculinity norms.

Additionally, across all three factors, men disagreed with the concept of using drugs to cope with their emotions. This is an interesting finding, as many of the men had a history of illicit substance misuse. Therefore, questions remain as to whether their views of drug use have changed since their admission for forensic services, or whether they were using illicit substances at the expense of their sense of masculinity due to feelings of being overwhelmed. Nonetheless, all the participants regularly receive anti-psychotic medication as part of their rehabilitation. Therefore, receiving anti-psychotic medication could possibly undermine their sense of masculinity. However, the findings are consistent with masculine norms in respect of being in control of oneself, others, and the environment (Robinson *&* Watt, 2001; Möller-Leimkühler, 2003). For example, participants within factors 1 and 3 reported that their perception of masculinity required them to protect and provide for their

family. Considering that admission to a forensic unit would inhibit a man's ability to fulfil roles in this regard, this may act as a slow trigger for violent behaviour.

The findings are mixed in regards to risk taking, as individuals who loaded onto factor 1 agreed with risk taking, whereas those who loaded onto factor 2 did not. Therefore, risk taking may not be related to psychosis, but may instead be related to men feeling trapped by cultural requirements to engage in risk-taking (Pittman, 1990) out of a sense of obligation to masculinity as opposed to a sense of freedom. Furthermore, the findings are mixed in respect of sexual activity, as within factors 1 and 2, participants agreed with the idea that men should be able to get erections, but disagreed with the idea of needing to have sex with multiple women. Therefore, it is likely that these men consider their sexual functioning as opposed to the number of their sexual conquests as being indicative of their masculinity.

Clinical and service implications

The findings have important clinical implications, and it would be potentially valuable to understand how these patterns of masculinity map onto coping, recovery style and service engagement. For example, the men consistently disagreed with the concept of using drugs to cope with their emotions, and for some men, the ability to achieve an erection was a significant factor in their representation of masculinity. Although the use of anti-psychotic medication can help to make psychotic experiences less frequent, intense or distressing, antipsychotic-induced sexual dysfunction is commonplace for many men who utilise such medication. Therefore, discussions in regards to the possibility of discontinuing the use of anti-psychotic medication within a risk assessment and a trusting, collaborative relationship between professional's and service users should be a necessary prerequisite of any treatment approach.

Furthermore, services could also benefit from becoming more aware of hospitalization being a shameful perhaps stigmatizing time for men with psychosis, especially considering that such men will be unable to protect and provide for their family which is a significant representation of their perceptions of masculinity. This could comprise of services asking men with psychosis specific questions about what support they or their families may need, and identifying the provision of extra support in response to these needs (Evenson et al., 2008). For example, inpatient units could ensure they are child-friendly so that men are able to meet their families in safe and comfortable surroundings, or provided with options in regards to engaging with their family members via alternative means of communication including telephone, email and skype messaging services.

The findings have also highlighted possible person centred therapy approaches for helping men cope with psychotic experiences. For example, participants who considered that arguing back with voices is representative of masculinity may benefit more from a cognitive behavioural therapy (CBT) approach, whereas for those participants who preferred to ignore such voices, an acceptance and commitment (ACT) approach may prove to be more congruent with their self-identity as a man.

The current findings also raise a number of service implications for men with a diagnosis of psychosis who reside in forensic services on a more general level. For example, public attention has increasingly been directed to concerns regarding the

quality of psychiatric inpatient provision (Woodward, Berry & Bucci, 2017). Therefore, therapeutic discussions in respect of masculinity itself could provide men with the opportunity to develop newer, more adaptive conceptualisations of themselves, help them develop greater self-awareness and understanding of the sources of their presenting concerns, which in turn could enhance a provisional formulation of their difficulties (Perelberg, 1999). Furthermore, if the care and treatment of men in forensic psychiatric care is to continue to have security and protection as its key aspects, it is possible that a greater consideration of masculinity, especially in consideration of risk, could enhance the effectiveness of existing custodial and community interventions into reducing recidivism and protecting the public (Whitehead, 2005).

It may also be necessary for staff members to be aware of how the service users they support perceive their masculinity, so the existential and deeper needs of male patients are provided with enough consideration (Kumpula & Ekstrand, 2009). Therefore, it is hoped that this research will help develop confidence and enhance the practice of practitioners in mental health professionals who are often reluctant or neglect to enquire about individual's psychotic experiences and gender identification (Semp & Read, 2014).

Limitations

The study was limited by its lack of longitudinal assessment and participants were not interviewed after the card sort task. It is therefore difficult to discern whether the participant's perceptions of masculinity were factors responsible for their admission to secure settings, whether they have changed since their admission or are likely to change in the future. Furthermore, as participants were not interviewed after the card sort, the interpretation of the findings remain speculative. Additionally, although the results of Q-studies are less influenced by low response rates compared with the results of survey studies (Brown, 1980; Brown, 1993; Mckeown & Thomas, 1988), and Q methodology acknowledges that no Q sort can ever be complete as every possible view cannot be included (Watts and Stenner, 2005), the inclusion of a greater number of participants may have enhanced the representativeness and generalizability of the findings. It should also be noted that the participant's beliefs were likely to have been influenced by years of exposure to mental health services. However, although it is possible that participants may have attempted to promote themselves in a positive light during interview, this is unlikely, as all participants were informed prior to interview that the information they shared would have no effect upon their prospective care or treatment.

Further research

Considering that attributions regarding the cause and potential responsibility for the acquisition of masculinity beliefs were not explored, further research in respect of attachment and masculinity with Q methodology could prove useful. For example, for those participants who considered that arguing back with voices was the right thing to do, research suggests that avoidant attachment styles may predispose individuals towards subduing intolerable affect (e.g. vulnerability) via less aversive affects such as anger, which may be experienced as empowering and increase feelings of self-reliance (e.g. "*I can protect myself*") (Darrell-Berry et al., 2017). Furthermore, service users have a unique perspective on services, and their views can be used to ensure that services are of high quality (Smith et al., 2014). Therefore, a Q methodological

study in respect of how services could improve their care of men with psychosis could prove useful.

Conclusions
The current study demonstrates that Q methodology allows for a collaborative exploration of what men with psychosis consider to be representative of masculinity. The results highlighted a heterogeneity of masculinity beliefs which could be used to help men with psychosis in respect of their coping, recovery style and service engagement.

IMPLICATIONS FOR PRACTICE

- Discussions in regards to the possibility of discontinuing the use of anti-psychotic medication within a risk assessment and a trusting, collaborative relationship between professional's and service users should be a necessary prerequisite of any treatment approach.
- Services could benefit from becoming more aware of hospitalization being a shameful perhaps stigmatizing time for men with psychosis
- There are possible person centred therapy approaches for helping men cope with psychotic experiences. This includes CBT for those who consider that arguing back with voices who belittle them is representative of masculinity, whereas ACT may be more beneficial for those individuals who prefer to ignore such voices as it may be more congruent with their self-identity as a man.
- Therapeutic discussions in respect of masculinity itself could provide men with the opportunity to develop newer, more adaptive conceptualisations of themselves, help them develop greater self-awareness and understanding of the sources of their presenting concerns, which in turn could enhance a provisional formulation of their difficulties
- A greater consideration of masculinity, especially in consideration of risk, could enhance the effectiveness of existing custodial and community interventions into reducing recidivism and protecting the public.
- Staff members could benefit from being aware of how the service users they support perceive their masculinity, so the existential and deeper needs of male patients are provided with enough consideration.

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